

# The 835 Health Care Claim Payment/Advice Tutorial

Michigan Department of Community Health  
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# Agenda

- ⊗ Welcome and Introductions
- ⊗ Terminology
- ⊗ EDI Overview
- ⊗ Introduction to the 835
- ⊗ 835 Transaction Detail
- ⊗ 835 Concepts and Examples
- ⊗ Paper RA
- ⊗ Data Clarification Memos
- ⊗ Q & A

# Terminology

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# Glossary

HIPAA/Industry Term	Medicaid Term	Description
Claim	Invoice	A single paper form, or a collection of services by a single billing provider for a single patient, billed at one time.
Service Line	Claim Line	A single service generally associated with a procedure code.
Replacement	Adjustment	A billing provider's request to change a previously submitted claim.
Void/Cancel	Adjustment	A billing provider's request to void a previously submitted claim.
Health Care Claim Adjustment		The difference between the claim or services' professional charges and the paid amount. The reason for the difference is described through the use of Health Care Claim Adjustment Reason Codes.
Subscriber	Recipient/Beneficiary	The individual who is enrolled in Medicaid and receives services.
Billing/Pay-to Provider	Provider	A health care practitioner like a hospital, nursing facility, physician or dentist that submits claims to be reimbursed for care they provide to patients (subscribers).

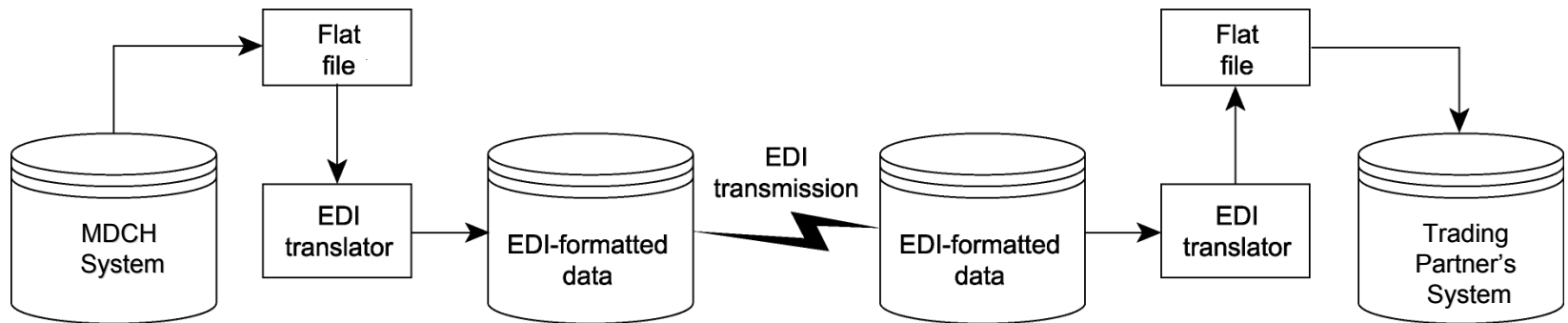
# HIPAA EDI Terminology

HIPAA ANSI X12 Term	Medicaid Term (if applicable)	Description
The American National Standards Institute (ANSI)		An organization that accredits a variety of standard-setting committees and monitors compliance with the Federal open-rulemaking process. The HIPAA Final Rule states that standards must be developed by an ANSI accredited committee.
Electronic data interchange (EDI)		Generally refers to the common formats for electronic exchange of data. The EDI format required by HIPAA is the X12 format for transactions.
Transaction		The exchange of information between two parties to carry out financial or administrative activities related to health care
Loop		A repeating section in an EDI transaction.
Segment		A group of related data elements within an EDI transaction
Simple Data Element		The smallest unit of information in an EDI transaction.
Composite Data Element		A more complex unit containing 2 or more of the simple data elements.
Delimiter		A character or number used to separate data elements in an EDI transaction.
Qualifier		A data element that precedes a particular segment in the EDI transaction that describes the type of information that is to follow in an EDI segment.

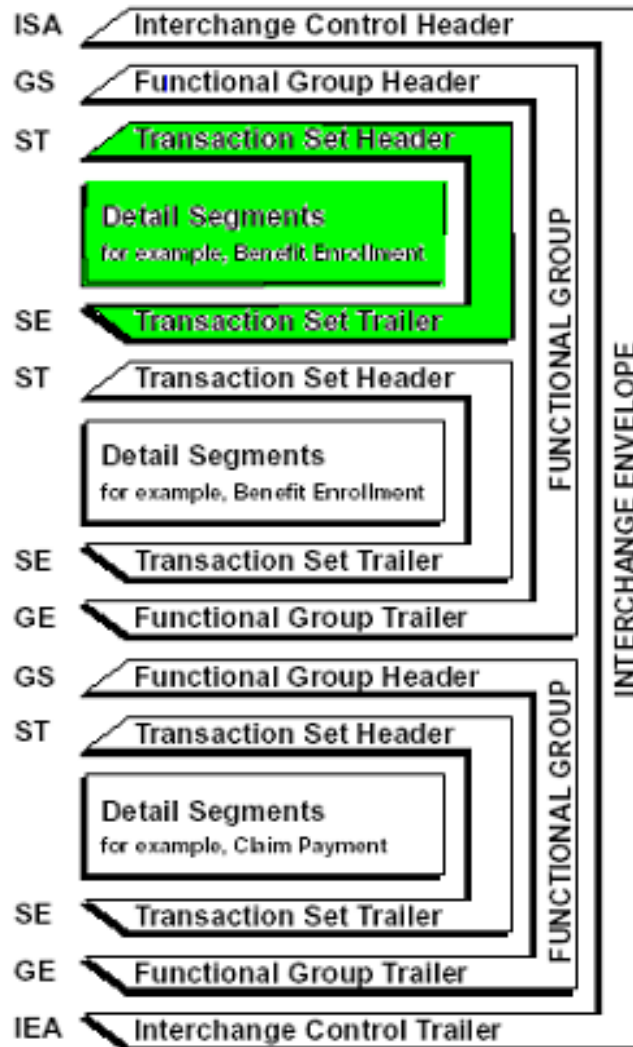
# EDI Overview

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# EDI Transaction Flow



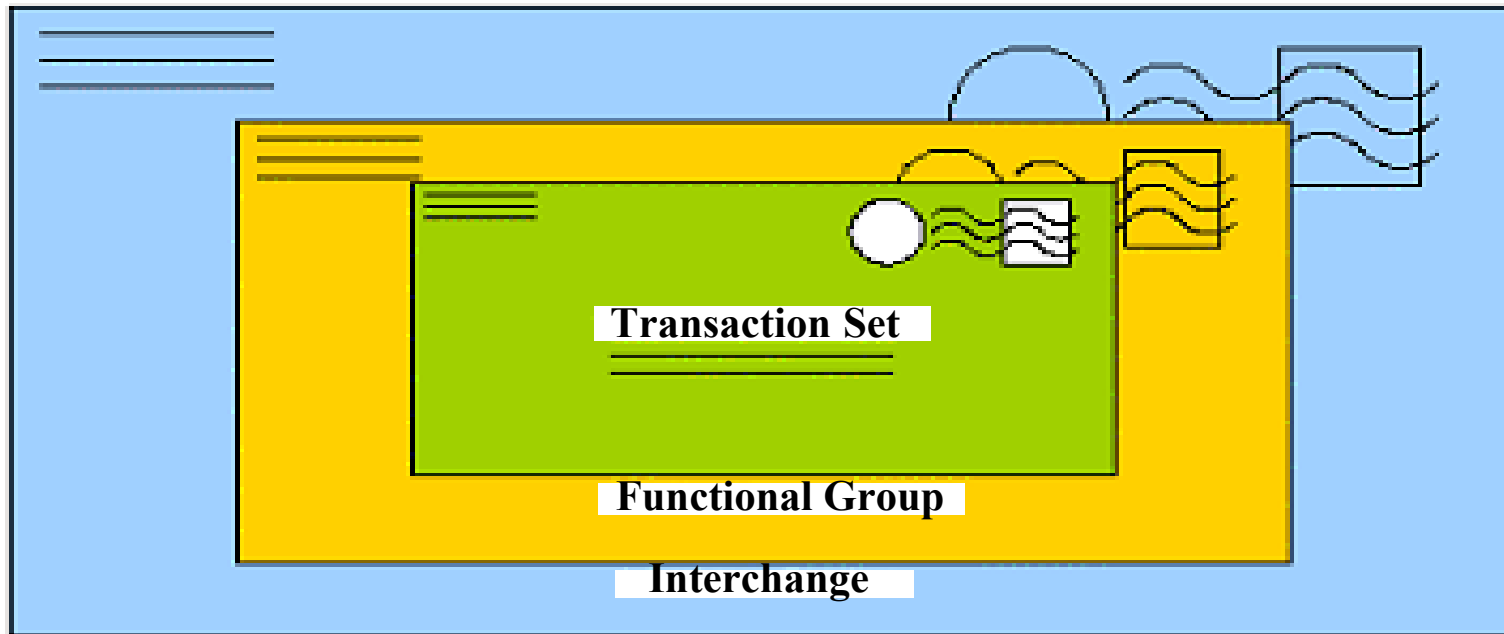
# EDI Structure Overview



- ✿ The interchange contains transactions for a specific receiver (service bureau)
- ✿ The functional group contains multiple similar transaction sets
- ✿ The transaction set contains remittance information for a specific payee



# EDI Envelope



# 835 Transaction Structure

## ST 835

1000A — Payer Identification

1000B — Payee Identification

2000 — Header Number

2100 — Claim Payment Information

2110 — Service Payment Information

PLB — Provider Adjustments

## SE 835

# Introduction to the 835

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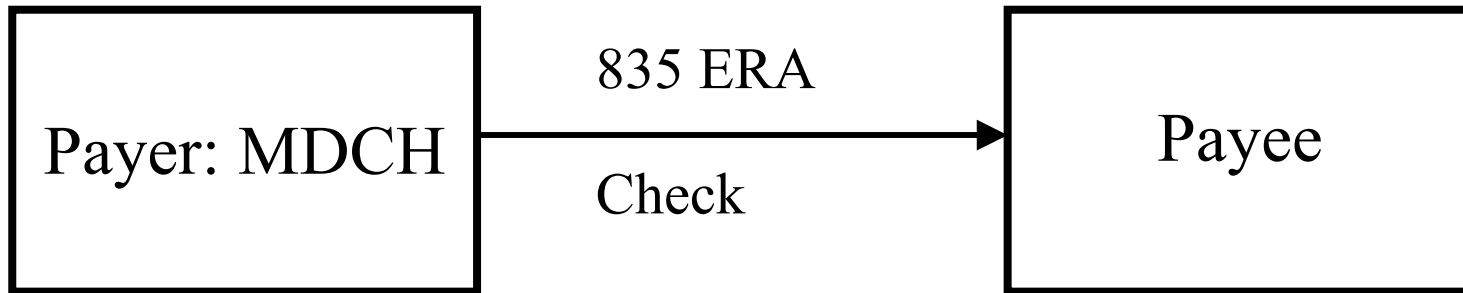
# 835 Overview

- HIPAA mandated standard transaction
- Used to transfer payment and remittance information for adjudicated dental, professional, and institutional health care claims
- Only Paid and Denied claims can be reported in an 835 transaction
- Pended information is transmitted via a 277 Unsolicited Claim Status
- Capitation payments are transmitted via the 820 Premium Payment transaction

# Relationship to Payment Device

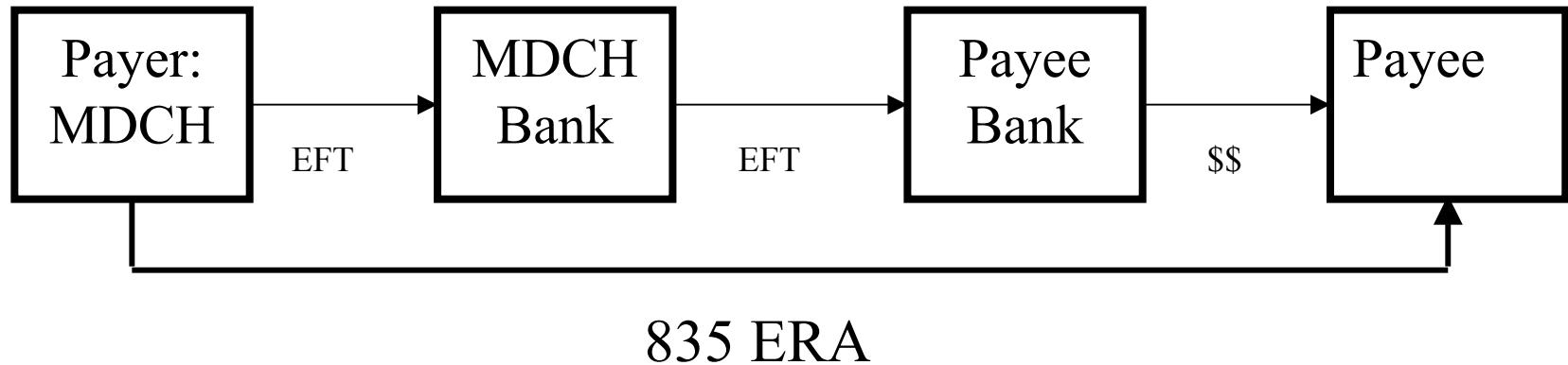
- One 835 transaction corresponds to one payment device
- Payment is sent from MDCH to a payee via check or EFT
- The entity receiving the payment is defined as the payee
- One 835 transaction corresponds to one payee
- A unique trace number is assigned by MDCH for reassociation

# Payment Made by Check



- ✚ The 835 reflects claims finalized during the pay cycle for one submitting provider
- ✚ Check number is used to reassociate the payment with remittance information
- ✚ Check amount and total transaction payment must be equal

# Payment Made by EFT



- The 835 reflects claims finalized during the pay cycle for all submitting provider under the Federal Tax Id associated with the EFT
- EFT trace number is used to reassociate the payment with remittance information
- EFT amount and total transaction payment must balance

# Balancing

● The 835 must balance at three levels:

■ Service level:

- Submitted Charges - Sum of Adjustments = Service Amount Paid (Loop 2110)

■ Claim level:

- Submitted Charges - Sum of Adjustments = Claim Paid (Loop 2100)

■ Transaction level:

- Sum of All Claim Payments - Sum of All Provider Adjustments = Total Payment Amount (Loop 2000)



# Features Not Supported by 835

- ✚ Diagnosis codes
- ✚ Tooth surface
- ✚ Proprietary codes
- ✚ Fund code information
- ✚ Reporting of pended claims
- ✚ No message page

# Advantages

- Serves as an input to the provider's billing and accounting systems
  - The 835 transaction is designed to allow easier posting and reconciliation of remittance information
  - It includes a trace number to identify the check or electronic funds transfer (EFT) payment
  - The provider's internal Medical Record Number, Line Item Control Number, and Patient Control Number will be returned, when submitted on the original claim

# 835 Transaction Detail

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# Table 1- Header Level

ST 835

## Header

- Financial Information
- Trace Number

### 1000A - Payer Identification

- MDCH address and phone number

### 1000B - Payee Identification

- Provider/Service Bureau Name

**Header**

2000 — Header Number

2100 — Claim Payment Information

2110 — Service Payment Information

**Detail**

PLB — Provider Adjustments

**Summary**

SE 835

# Table 1 – Header Level

## Financial Information

- Transaction total payment amount must reconcile to the check or EFT amount
- Treasury Information

## Trace Number

- Check Number or EFT Number

## 1000A - Payer Identification

- Identifies the payer (MDCH)
- Contact phone number: 800-292-2550
- Email address: [providersupport@michigan.gov](mailto:providersupport@michigan.gov)

## 1000B - Payee Identification

- Federal Tax ID of payee

# Table 2 - Detail Level

**ST 835**

Header

1000A - Payer Identification

1000B - Payee Identification

**Header**

**2000 — Header Number**

- Provider summary

**2100 — Claim Payment Information**

- Monetary Amounts
- Claim Status Code
- Claim Adjustments
- Patient Name, Service Provider
- Corrected Priority Payer
- Prior Authorization, Medical Record Number

**Detail**

**2110 — Service Payment Information**

- Monetary Amounts
- Procedure Code, Modifiers, and Revenue Code
- Adjustments, Remark Codes

PLB — Provider Adjustments

**Summary**

**SE 835**

# Loop 2000 – Header Number

## Provider Summary Information

### Provider ID

- Medicaid Provider ID
- Loop is created for each Provider ID

### Facility Type Code

- Identifies where the services were performed
- The first and second positions of the Uniform Bill Type code or Place of Service

### Conveys the following for each Provider ID:

- Total number of claims
- Total charge amount
- Total provider payment amount

# Loop 2100 – Claim Payment Information

## Claim Payment Information

### ● Patient Control Number

- Assigned by the provider
- Primary key for posting claim information
- Will be reported for paper and electronic claims

### ● Claim Status Code – status for the entire claim

- 1 – Processed as Primary
- 2 – Processed as Secondary
- 4 – Denied
- 22 – Reversal of a Previous Payment



# Loop 2100 – Claim Payment Information

## Claim Payment Information

- Claim Filing Indicator - “MC” (Medicaid)
  
- Conveys the following information:
  - MDCH Claim Reference Number
  - Original facility type code if modified through adjudication
  - Claim Frequency Code
  - DRG Code and Weight

# Loop 2100 – Claim Payment Information

## Claim Adjustment

- Reports the difference between the claim charged amount and the claim paid amount
- Institutional claims will utilize this segment (i.e. PT 30, paid claims)
- Adjustment information includes:
  - Claim Adjustment Group Code
  - Claim Adjustment Reason Code
  - Claim Adjustment Amount
  - Claim Adjustment Quantity

# Loop 2100 – Claim Payment Information

## ❁ Patient Name

- ❁ Parsing name from the Recipient Database
- ❁ Medicaid Recipient ID Number
- ❁ Corrected Patient Name is currently not reported

## ❁ Service Provider Name

- ❁ Required when rendering provider is different than Payee
- ❁ Will be transmitted by MDCH

# Loop 2100 – Claim Payment Information

## ❁ Corrected Priority Payer

- ❑ Will transmit Carrier Name and Carrier ID of the payer that results in the claims being denied
- ❑ Additional other insurance information is provided through separate transactions

## ❁ Claim Related Information (when available on the claim)

- ❑ Prior Authorization Number
- ❑ Medical Record Number

# Loop 2110 – Service Payment Information

## Service Payment Information

- ✿ Is not generated when payment is at the claim level
- ✿ Must report both submitted and adjudicated composite Medical Procedure Code and Quantity, when different
  - ▣ Procedure ID Qualifier
  - ▣ Procedure Code
  - ▣ Procedure Modifiers (up to four)
- ✿ Revenue code is reported when considered during adjudication

# Loop 2110 – Service Payment Information

## Service Adjustment

- Reports the difference between the service line charged amount and the service line paid amount
- Adjustment information includes:
  - Claim Adjustment Group Code
  - Claim Adjustment Reason Code
  - Claim Adjustment Amount
  - Claim Adjustment Quantity

# Loop 2110 – Service Payment Information

## ☼ Service Identification

- ▣ Provider Line Control Number
- ▣ Prior Authorization sent at the claim level

## ☼ Health Care Remark Codes

- ▣ Information only, does not impact balancing
- ▣ One remark code will be conveyed for each MDCH edit code set at the service line
- ▣ If no service line is transmitted no remark code is conveyed (i.e. DRG payments)

# Table 3- Summary Level

**ST 835**

Header

1000A - Payer Identification

1000B - Payee Identification

**Header**

2000 - Header Number

2100 - Claim Payment Information

2110 - Service Payment Information

**Detail**

## **PLB - Provider Adjustments**

- Adjustment Reason Code
- Adjustment ID
- Adjustment Amount

**Summary**

**SE 835**



# Table 3 – Summary Loop

## Provider Adjustment

- Non-Claim related adjustments
  - MDCH Gross Adjustments, such as MIP payments
  - Supports both credit and debit adjustments
- Adjustment Identifier
  - Composite Identifier that conveys the reason for the adjustment
  - Adjustment Reason Code
    - Standard code
  - Provider Adjustment Identification
    - MDCH proprietary Gross Adjustment code
- Adjustment Amount

# 835 Concepts and Examples

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# Standard Claim Adjustment Codes

- Each proprietary code has been crosswalked to standard claim adjustment codes
  - **Claim Adjustment Group Codes** - Identify the general category of the payment adjustment
  - **Claim Adjustment Reason Codes** - Communicate why a claim or service line was paid differently than it was billed
  - **Remark Codes** - Used to relay service-specific informational messages that cannot be expressed with a reason code
- Standard claim adjustment codes will be transmitted on the paper RA

# Standard Adjustment Reason Codes

- ✿ Used when making non-claim specific adjustments (i.e. provider level)
- ✿ Describes the reason why the payment was increased or decreased
- ✿ Similar to MDCH Gross Adjustment (GA) Code
- ✿ MDCH codes have been crosswalked to the standard codes
- ✿ Both standard and proprietary codes will be transmitted in the 835

# Balancing

- The 835 must balance at three levels:
  - Service level: Submitted Charges - Sum of Adjustments = Service Amount Paid (Loop 2110)
  - Claim level: Submitted Charges - Sum of Adjustments = Claim Paid (Loop 2100)
  - Transaction level: Sum of All Claim Payments - Sum of All Provider Adjustments = Total Payment Amount (Loop 2000)

# Balancing Example

## Service Balancing

### Service Line

Amount Charged	\$ 50.00	
Adjustment Amount	<u>\$ 21.29</u>	→ CO 42 N14
Service Line Paid	\$ 28.71	

**Group Code** = CO (Contractual Obligation)

**Reason Code** = 42 (Charges exceed our fee schedule)

**Remark Code** = N14 (Payment based on contractual amount)

# Balancing Example

## Service Balancing

### Service Line

Amount Charged \$ 50.00

Adjustment Amount        \$ 50.00    CO   16   MA61   MA66

Service Line Paid \$   0.00

**MDCH edits** =   0019 and 0089

**Group Code** =   CO    (Contractual Obligation)

**Reason Code** =   16    (Claim/service lacks information which is needed for adjudication)

**Remark Code** = MA61 (Did not complete or enter correctly the patient social security number or health insurance claim number)

**Remark Code** = MA66 (Incomplete/invalid principal procedure code and/or date)

# Balancing Example

## Claim Line

Amount Charged      \$150.00  
Adjustment Amount   \$ 76.88  
Claim Line Paid      \$ 73.12

## Service Line 1

Amount Charged      \$ 50.00  
Adjustment Amount   \$ 21.29 CO 45  
Service Line Paid      \$ 28.71

## Service Line 2

Amount Charged      \$100.00  
Adjustment Amount   \$ 55.59 CO 45  
Service Line Paid      \$ 44.41



# Balancing Example

## Professional Claim

		Charged	Adjustment	Payment	Group	Reason	Remark	Remark	Remark
✚	Claim 1	995.29	77.80	917.49					
	▣ Service 1	217.28		217.28			N36	N14	
	▣ Service 2	81.48	20.00	61.48	CO	42	N14		
	▣ Service 3	191.70	10.00	181.70	CO	3	N45		
	▣ Service 4	81.48	20.00	61.48	CO	42	N14	N14	
	▣ Service 5	159.75		159.75			N36	N14	
	▣ Service 6	127.80	27.80	100.00	CO	42	N14		
	▣ Service 7	135.80		135.80			N36	N14	

		Reason	Adjustment ID	Amount
✚	Provider Adjustment	WO	25	10,000.00

# Balancing Example

## Institutional Claim

		Charged	Adjustment	Payment	Group	Reason	Remark	Remark	Remark
⊗	Claim 1	8082.08	5639.57	2442.51	CO	42	N14	N14	
⊗	Claim 2	5944.00	3204.25	2739.75	CO	42	N14	N14	
⊗	Claim 3								
	▣ Service 1	119.40	119.40	0.00	CO	16	N15	MA63	
	▣ Service 2	119.40	119.40	0.00	CO	16	N15	MA63	
	▣ Service 3	119.40	119.40	0.00	CO	16	N15	MA63	

		Reason	Adjustment ID	Amount
⊗	Provider Adjustment	PI	08	300.00

# Reversals and Corrections

- When a claim is paid in error, the original claim payment is reversed and corrected data is sent
  - Similar to a “void/cancel”
  - Can no longer “replace” a claim
- All original charge, payment, and adjustment amounts are negated at either the claim or service level
- This restores the patient accounting system to the pre-posted balance
  - Claim status code = 22 (reversal of previous payment)
  - Claim adjustment group code = CR (claim reversal)

# Paper RA

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# Changes to the Paper RA

- Standard codes will replace proprietary codes
  - Claim adjustment group, reason and remark codes
  - Provider adjustment codes
  - Claim status codes
  
- Additional changes of consideration
  - Suppress reporting of tooth surface
  - Report Provider Line Item Control Number

# Data Clarification Documents

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# Data Clarification Documents

- Data clarification documents were created as a companion to the National Electronic Data Interchange Transaction Set Implementation Guides
- Data Clarification Documents can be found on the MDCH web site: <http://michigan.gov/mdch>

# Questions and Answers

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